ARKANSAS INSURANCE DEPARTMENT
LEGAL DIVISION
1200 West Third Street
Little Rock, AR 72201-1904
501-371-2820
FAX 501-371-2629

RULE AND REGULATION 21

COORDINATION OF BENEFITS - DISABILITY INSURANCE POLICIES

SECTION 1. AUTHORITY

The Rule is adopted and promulgated by the Arkansas Insurance Department pursuant to the authority provided in Ark. Code Ann. §23-85-132 and §23-61-108, §23-86-111, §25-15-201 et. seq., and other applicable provisions of the Arkansas Insurance Code.

SECTION 2. APPLICABILITY

This Regulation applies to all individual major medical insurance policies, as defined in Rule and Regulation 18, all catastrophic expense policies, all non-renewable ticket disability policies, all group disability policies, including group contracts of Hospital and Medical Service Corporations, and certificates of group insurance covering residents of Arkansas under master policies issued elsewhere.

SECTION 3. COORDINATION WITH "NO-FAULT" AUTO INSURANCE

For purposes of Coordination of Benefits (hereinafter referred to in this Regulation as COB) with group policies of disability insurance and the classes of individual policy which are specifically allowed to reduce benefits due to the existence of other insurance under the terms of Ark. Code Ann. §23-85-132, coverage designated (A) below is to be considered primary when payment is made under an automobile liability policy.

Effective July 1, 1974, automobile liability policies issued in Arkansas must include (unless specifically rejected by named insured) the following coverages:

A. Medical and Hospital Benefits. All resonable and necessary expenses for medical, hospital, nursing, dental, surgical, ambulance, and prosthetic services incurred within twenty-four (24) months after the automobile accident, up to an aggregate of $2,000 per person, which may include any non-medical remedial care and treatment rendered in accordance with a recognized religious method of healing. Expenses for hospital room charges may be limited to semi-private accommodations.

B . Income Disability Benefits. Seventy percent (70%) of the loss of income from work during a period commencing eight (8) days after the date of the accident, not to exceed fifty-two (52) weeks, but subject to a maximum of $140 per week. In the case of a non-income earner, such benefits shall consist of expenses not to exceed $70 per week, or any fractional part thereof, which are reasonably incurred for essential services in lieu of those the injured person would have performed without income during a period commencing eight (8) days after the date of the accident, not to exceed fifty-two (52) weeks.

C. Accidental Death Benefits. The sum of $5,000 to be paid to the personal representative of the insured, should injury, sickness, or disease resulting from an automobile accident caused death within one (1) year from the date of the accident.

Insurers writing these benefits under automobile liability policies are permitted to exclude benefits only when the insured's conduct contributed to the injury either as intentional self-injury, while in the commission of a felony, or while

seeking to elude arrest. The principle of tort liability is retained, and automobile liability insurers may recover amounts expended as such benefits (except death benefits) from amounts recovered by an insured in tort.

SECTION 4. POLICY PROVISIONS RELATING TO CORRDINATION OF BENEFITS IN GROUP DISABILITY INSURANCE POLICIES

A. If a group disability policy contains an overinsurance provision, the provision must be consistent with the model group COB provisions adopted by the National Association of Insurance Commissioners and the guidelines herein established. To this end, overinsurance provisions, or provisions for the reduction of benefits otherwise payable because of other insurance by whatever name designated, other than the model coordination of benefits provisions herein contained may not be used, except that plans of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

GUIDELINE ONE: Definition of a "Plan": Individual and Group Contracts. The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. Such definition:

(1) May not include individual or family policies, or individual or family subscriber contracts, except as provided in subparagraph (2).

(2) May include all group or blanket disability policies or group subscriber contracts of hospital and medical service corporations, union welfare plans, employer or employee benefit organization or workmen's compensation insurance as well as policies which are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Contracts answering this description may be included in the definition, at the option of the insurer and its policyholder-client whether or not individual policy forms are utilized and whether the coverage is designated as "franchise" or "blanket" or in some other fashion. Accordingly, within this rule, individually underwritten and issued hospital, medical expense, or dread disease policies, including cancer insurance shall not be considered coverage to which a COB provision may be applied, even though the premiums for such coverage may be paid through payroll deduction or similar basis, or the employer, association, or other entity serves as a conduit through conduit through which premiums are paid, unless premiums are paid by the employer with no contribution made by the employee.

GUIDELINE TWO: Definition of a "Plan": "No-Fault" Automobile Insurance. The definition of "plan" may include Medical and Hospital benefits under eiEher group or individual automobile "No-Fault" contracts to the extent provided above but ' as to the traditional automobile tort liability contracts, only the medical benefits written on a group or group-type basis may be included.

GUIDELINE THREE: Definition of a "Plan": Hospital Indemnity Type Coverages. Interpretation of the definition of a "Plan" may not include group hospital indemnity benefits (written on a non-expense incurred basis) of $30 per day or less. The amount of group hospital indemnity benefits which exceeds $30 per day may be construed as being included under the definition of a "Plan".

GUIDELINE FOUR: Definition of Plan: Student Accident Coverages Student accident type coverages, written on either an individual, group, blanket or franchise basis, should not be considered a Plan under this Regulation. In this context student accident coverage is defined to mean coverage covering students, ~e they grammar school, high school, college or post-high school education for accidents only, including athletic injuries, either on a 24-hour basis, or "to and from school". Student accident coverages may be sold on an excess basis.

GUIDELINE FIVE: Definition of "Allowable Expense". "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

GUIDELINE SIX: Order of Benefit Determination. When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved shall use the following rules to decide the order in which the benefits payable under the respective plans will be determined.

(1) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent, and benefits of Plan

which covers such person as an employee shall be determined before the benefits of a Plan which covers such person as a member;

(2) The benefits of the Plan which covers the person on whose expenses claim is based as a dependent of the parent whose birthday falls earlier in the year shall be determined before those of the parent whose birthday falls later in that year;

(3) If both parents have the same birthday, the benefits of the Plan which has covered the parent the longest are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the birthday rule as described in (2) above, but instead has a rule based upon the gender of the parents, and as a result the Plans do not agree on the order of benefits, the rule in the other Plan utilizing the gender rule will determine the order of benefits;

(4) In the case of divorced or separated parents, the benefits for a child will be determined as follows:

(a) First the plan of the parent with custody of the child;

(b) Then the plan of the spouse of the parent with the custody of the child;

(c) Finally, the plan of the parent not having custody of the child;

(d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) When Rules (1) and (2) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

NOTE:

(1) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be determined to be on continous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g. single employer to multiple employer Plan or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this guideline.

(2) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, Union, association, etc.) then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this guideline, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under the Plan has been in force.

GUIDELINE SEVEN: Excess Coverages (i.e. Self-insurance and Other Non-Regulated Group Contracts). Carriers shall use the following claims administration procedures when one contract is "excess" to all other coverage and the other contract (group health) contains the COB provision:

A group contract should pay first if it would be primary under the COB order of benefit determination. In those cases in which it would normally be considered secondary, the carrier should make an effort to coordinate in the secondary position with benefits available through such "excess" plans. The carrier should try to secure the necessary information from the "excess" plan. But if such plan is unwilling to provide the carrier with the necessary information, the carrier should assume the primary position because it has no legal authority to do otherwise.

GUIDELINE EIGHT: Coordinating Benefit Payments. Carriers shall use the following claims administration procedures to expedite claim payments where COB is involved:

(1) Improving exchange of benefit information.

(a) Education of claim personnel shall stress accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring carrier and the responding carrier. This education effort and its continual improvement should also be encouraged through local claims associations.

(b) Claim personnel shall make every effort, including the use of the telephone, to speed up exchange of COB information.

(2) Each carrier shall establish a time limit after which full or partial payment should be made. Such time limit shall not extend for more than ninety (90) days after receipt of completed claim forms. When payment of a claim is necessarily delayed for reasons other than the application of a COB provision, investigation of other valid coverages shall be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally this will necessitate a carrier making payment as the primary carrier with a right of recovery in the event that subsequent investigation proves that payment as a secondary carrier should have been made. Attention is called to Ark. Stat. Ann. §66-3005 (9).

GUIDELINE NINE: Small Claim Waivers. Carriers are directed to waive the investigation of possible other coverage for COB purposes on claims less than $100, but if additional liability is incurred which raises the small claim above $100, the entire liability may be included in the COB computation.

GUIDELINE TEN: Public Education. Each carrier has an affirmative obligation to urge its respective group clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of COB. Such educational effort may take the form of articles in the company magazines or newspapers, speeches before the appropriate labor organizations in the case of a unionized company, brochures added to pay envelopes, notices on the company bulletin board, materials used by personnel departments in counseling employees, and the like. Employers should be urged to apply dividends or retrospective rate reductions (experience refunds) to the reduction of employees' contributions to premiums, and to make such reductions known to employees.

GUIDELINE ELEVEN: Notice to Insureds. Each certificate issued under a master policy containing COB provisions shall contain a full explanation of said provision, shall state the time limit established in accordance with Guideline Eight, Paragraph (2), and shall display prominently across its face or as a part of its schedule of benefits the words: "COORDINATION OF BENEFITS INCLUDED - SEE PAGE _____". The existence of such provision shall be specifically disclosed in enrollment material.

GUIDELINE TWELVE: Retroactivity. Group contracts which are in force at the time of promulgation of these Guidelines and which contain a COB provision not fully in compliance with these Guidelines, shall be brought into compliance by the later of the next anniversary or renewal date of the group contract or the expiration of the applicable collectively bargained contract, if any.

B. Those individual policies which may contain provisions reducing benefits due to the existence of one or more other policies of insurance as provided in Ark. Code Ann. §23-85-132 need not incorporate all the provisions required for group contracts, but shall, insofar as is possible, incorporate the same principles. Guidelines Six, Eight, and Nine are of particular merit in this respect. Specific guidelines applying only to such policies are:

GUIDELINE THIRTEEN: Notice to Insureds. Such provisions are of the nature of reductions and shall be set forth as provided in Ark. Code Ann. §23-85-104. In addition, the words, "OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY" shall be displayed prominently across the face of the policy and the application shall obtain the applicant's specific permission for such reduction of benefits. The existence of such reduction shall be specifically disclosed in any advertising of the policy.

GUIDELINE FOURTEEN: No such provision shall operate to reduce total benefits under all applicable coverages below the lesser of one hundred percent (100%) of allowable expenses or the maximum payable under all policies involved.

SECTION 5. EXCEPTIONS, REQUIRMENTS

Contracts of group insurance covering employees whose employer pays 100% of the premiums are specifically exempt from these requirements by Ark. Code Ann. §23-86-111. That Act was intended to exempt coverage of dependents of those employees, provided the employee does not contribute to the premiums. In addition, there may be occasions where coverage is provided under a group policy issued to other than a multiple employer trust outside the State of Arkansas which contains conflicting COB provisions. In such cases, Guideline Eleven shall apply, excepting that the words, "RESTRICTIVE COORDINATION OF BENEFITS INCLUDED READ CAREFULLY", or, "EXCESS COVERAGE ONLY - SEE PAGE _____", shall be displayed prominently across the face of each certificate.

Each insurer issuing group policies outside of Arkansas to which this section applies is requested to file certificates properly stamped with the Arkansas Insurance Department.

Each insurer issuing group policies to multiple employer trusts located outside Arkansas are requested to file certificates which will comply with the provisions of this Regulation and to certify that Arkansas business will be administered in accord herewith.

SECTION 6. SEVERABILITY

If any section or portion of a section of these Rules, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of the Rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

SECTION 7. EFFECTIVE DATE

It is hereby determined that immediate action on this Rule is necessary in order to provide uniform regulation of disability insurance policies. The effective date of this regulation is July 1, 1988.

(Signed by Robert M. Eubanks III
Robert M. Eubanks III
Insurance Commissioner

(Dated May 25, 1988)
Date